Leqvio® (inclisiran) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: start date ____/____/____ ☐ Continuation of therapy, date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Cardiologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Leqvio (inclisiran) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Please indicate the current LDL-C level in mg/dL: _____

☐ Yes ☐ No Does the patient have a documented diagnosis of primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH)?

For Initiation Requests (clinical documentation required):

☐ Yes ☐ No Is the request for a loading dose?

☐ Yes ☐ No Will the patient continue to receive concomitant statin therapy?

→ ☐ Yes ☐ No Does the patient have an intolerance or a contraindication to high-intensity statin therapy?

Please indicate the prior therapy the patient has previously received (select all that applies to the patient):

☐ The patient is receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily

→ Please indicate the start date: ____/____/____

☐ Yes ☐ No Has the patient received this dose for at least 3 months?

→ ☐ Yes ☐ No Was the patient unable to tolerate a high-intensity statin due to adverse effects?

☐ The patient is receiving a moderate-intensity statin dose daily, such as atorvastatin (Lipitor) 20 mg or equivalent

→ Please indicate the start date: ____/____/____

☐ Yes ☐ No Has the patient received this dose for at least 3 months?

☐ The patient has had an intolerance to a high-intensity statin

→ ☐ Yes ☐ No Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI)?

☐ Yes ☐ No Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin?

Continued on next page

Leqvio® (inclisiran) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ The patient has a contraindication to high-intensity statin therapy
→ Please indicate which of the following applies to the patient:
- ☐ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase [ALT] level greater than or equal to 3 times the upper limit of normal)
- ☐ Currently pregnant
- ☐ Planning pregnancy
- ☐ Breastfeeding
- ☐ None of the above

For patients **WITH** a history of clinical atherosclerotic cardiovascular disease (ASCVD):
Please indicate which of the following manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) the patient has experienced:
- ☐ Acute coronary syndrome
- ☐ Coronary Artery Calcium (CAC) score of greater than or equal to 1000
- ☐ Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery)
- ☐ Myocardial infarction
- ☐ Non-cardiac peripheral arterial disease (PAD) of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD)
- ☐ Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)
- ☐ Stable or unstable angina
- ☐ Stroke of presumed atherosclerotic origin
- ☐ Transient ischemic attack (TIA)
- ☐ Other

For patients **WITHOUT** a history of clinical atherosclerotic cardiovascular disease (ASCVD):
Please indicate the patient's untreated (before any lipid-lowering therapy) LDL-C level in mg/dL: _____
☐ Yes ☐ No Are there any secondary causes that could explain the elevated untreated LDL-C?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C) as the result of treatment with the requested medication?

Please indicate which of the following applies to the patient:

☐ The patient is currently receiving concomitant statin therapy
→ ☐ Yes ☐ No Will the patient continue to receive concomitant statin therapy?

☐ The patient has had an intolerance to a high-intensity statin
→ ☐ Yes ☐ No Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI)?
→ ☐ Yes ☐ No Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin?

☐ The patient has a contraindication to high-intensity statin therapy
→ Please indicate which of the following applies to the patient:
- ☐ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase [ALT] level greater than or equal to 3 times the upper limit of normal)
- ☐ Currently pregnant
- ☐ Planning pregnancy
- ☐ Breastfeeding
- ☐ None of the above

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.